ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXII AUGUST, 1958 No. 8

EDITORIAL

—Lord Moran said he was not happy about the quality of the entry of students in the medical schools. " Not long ago, middle-class parents paid for all medical students' fees. Now, two-thirds of the students are maintained by the State and they are selected by examination without any test of, or regard to, character.

" That can only end in disaster, and there are signs of the effect of it already. You cannot select solely on examinations for a profession like Medicine, which requires the human touch more than anything else."—

Daily Telegraph.

Among many things spoken and written on the occasion of the 10th anniversary of the National Health Service, the above report of Lord Moran's speech has aroused no little interest amongst medical undergraduates. This constitutes no condemnation of the student, who chooses neither his parents nor his election to a medical school, but, nevertheless, he is entitled to examine the validity of the hypothesis. Perhaps the findings of our own Questionnaire—which should be available in the near future—will elucidate various aspects of this problem.

" Maintained " implies full financial support by the State or other public body, but it is very doubtful whether even 10% of students receive a full emolument. Furthermore, it is very unlikely that, even on receipt of a full State award, a student is wholly self-sufficient. Since many scholarships are subject to a parental financial means test, the majority of Lord Moran's 66% receive only a portion of the maximum award, which may mean as little as one-quarter of the hospital fees. The inference that this 66% is now derived from different classes in these State aided days, is probably erroneous, because the entry still may be derived from essentially the same sources as previously, but now receive some State financial aid. Financial awards are assessed on gross income, and the difference between a maximum award is to be met by the parents. The standard income of the professional class parent has increased in proportion far less than that of most other occupations ; thus, combined with the higher cost of living and the present taxation system, such parents may be comparatively less fortunate than in preceeding years.

Examinations constitute an inescapable part of medical undergraduate life. A certain educational standard has been demanded always of potential doctors. The general opinion regarding pre-medical school education, is that it is far too narrow. Fortunately, there exists within the ranks of medical students a few who have had a

broader education in the classics and other arts. Although examination successes must play an essential part in the selection of potential medical students, it is hoped that testimonials and personal interview count in some measure. If only written and practical work counts in election, then selection committees are to be condemned, and this must include Lord Moran himself, a former Dean of a Medical School. Perhaps a more comprehensive system of interviews and personal selection could be instituted by the initiative of the medical schools. If the quality of applicants is below standard, then the medical schools should reduce their intake, and not increase it as various schools have done in past years.

An individual's possession of the " human touch " may be of importance, but cannot be assessed except over a long period of time. The many years of training in the art of Medicine provide ample opportunity to ascertain character, possession of the " human touch " and determination of technical ability. However, it is doubtful whether the possession of these three qualities can be pre-determined by examinations, social origin, nor whether or not a fee payer.

Lord Moran does not elucidate his " signs of disaster." Maybe they are early signs, for the time of ascent to the top of the profession is long. Perhaps a day will dawn when an elder generation in any sphere of life will accept the possibility that a succeeding generation could measure up to their own high standard.

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INTERNATIONAL CANCER CONGRESS

The Hospital acted as host to members of the International Cancer Congress on July 16th. Their programme included :—

Morning.

1. Demonstration of research work carried out by the Linear Accelerator Research Unit. **(Prof. J. Rotblat and staff.)**
2. Demonstrations by the Biochemistry Department.
   (a) Zinc and cancer tissues. **(Prof. A. Wormall and staff.)**
   (*b*) Action of radiations on some fatty acids. **(Dr. E. D. Wills.)**
   (*c*) Actions of radiations on complement, enzymes and trypanosomes. **(Prof. A. Wormall and Dr. E. D. Wills.)**
3. The first Gordon-Watson Memorial Lecture—" A Pioneer in the Attack of Cancer," delivered by **Mr. R. S. Corbett.**

Afternoon.

A series of demonstrations in the Great Hall :—

1. Tumours of the glomus jugulare. **(Mr. F. C. W. Capps and Dr. R. A. Kemp Harper.)**
2. Tumours of the thymus. **(Mr. I. G. Williams and Dr. R. A. Kemp Harper.)**
3. Breast cancer: correlation between clinical follow-up and oestrogen studies. **(Dr. E. F. Scowen and Mr. G. J. Hadfield.)**
4. Myelomatosis. **(Dr. R. Bodley Scott and Dr. J. Q. Matthias.)**
5. Retinoblastoma : treatment by radio-cobalt applicators. **(Mr. H. B. Stallard and Dr. A. E. Jones.)**
6. The clinical significance of malignant cells in the sputum. **(Dr. G. Canti.)**
7. Investigations of ketosteroids in malignant disease. **(Dr. A. M. Robinson, Miss A. Dimoline and Miss D. G. Jones.)**
8. Uterine cancer : a preliminary study of the value of colposcopy in the diagnosis of early cervical carcinoma. **(Mr. J. Beattie and Mr. J. D. Andrew.)**
9. A demonstration of the archives of the Hospital, and of some writings on cancer by Bart's men. **(John L. Thornton,** Librarian and the Hospital Archivist's Office.)

Members were guests of the Board of Governors to lunch and tea.

RADIOLOGISTS A.G.M.

The Annual General Meeting of the

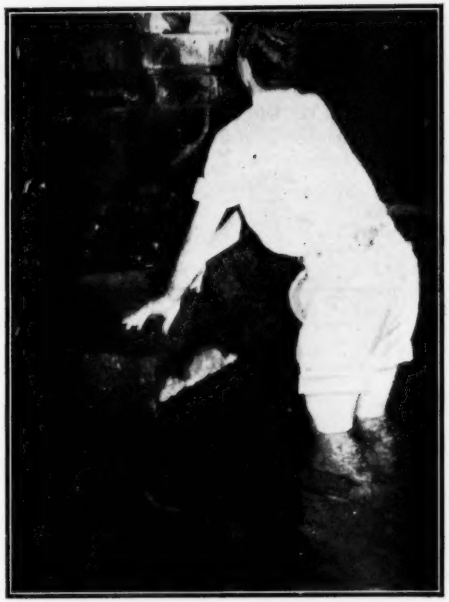
Faculty of Radiologists was held on June 13th, 1958, in the Royal College of Surgeons, during which a Symposium on Retroperitoneal Tumours was presented to a joint meeting of the Diagnostic and Radiotherapy Sections. The speakers were all members of the staff of St. Bartholomew's Hospital. **Professor J. W. S. Blacklock** discussed the widely varied pathology of these tumours and illustrated his remarks from a large collection of material gathered during his career in teaching hospitals in Glasgow, as well as those in St. Bartholomew's Hospital. **Mr. R. S. Corbett** discussed the surgical problems involved in these tumours, and quoted cases encountered by himself and his surgical colleagues. **Dr. Kemp Harper** described the problems which arise in Diagnostic Radiology and illustrated the diverse manner in which radiological features were found and demonstrated. **Mr. I. G. Williams** drew on his experience in St. Bartholomew's Hospital and the Hospital for Sick Children, Great Ormond Street, to present the difficulties and results of Radiotherapy treatment of such tumours. The meeting was very well attended, and the presentation of each of the speakers' personal experiences in relation to these tumours, rather than a formal presentation, was much appreciated.

GORDON - WATSON MEMORIAL LECTURE

Mr. R. S. Corbett, M.Chir., F.R.C.S., gave the first Gordon-Watson Memorial Lecture —" A Pioneer in the Attack of Cancer "— on July 16th, in the Physiology Lecture Theatre at Charterhouse. Amongst the audience were members of the International Cancer Congress.

FACELIFT TO FOUNTAIN?

The already begrimed fountain is now threatened by evergrowing vegetation. Several public-spirited nurses have offered to give the stonework a " spring clean." Closer inspection reveals the possible need for structural repairs.



Nocturnal Cleaner or View Day Hoaxer?

CHANGE OF PRINTERS

This edition of the *Journal* is the first to be completed by our new printers, Groves, Brodie & Co. Ltd., of Slough. We look forward to a long and successful association with this firm.

CALENDAR

August

Sat., 2nd.—Medical and Surgical Units on duty.
Mr. G. H. Ellis on duty.

Sat., 9th.—Dr. Geoffrey Bourne on duty.
Mr. J. B. Hume on duty.
Mr. F. T. Evans on duty.

Sat., 16th.—Dr. A. W. Spence on duty.
Mr. C. Naunton Morgan on duty.
Mr. R. A. Bowen on duty.

Sat., 23rd.—Dr. R. Bodley Scott on duty.
Mr. R. S. Corbett on duty.
Mr. R. W. Ballantine on duty.

Sat., 30th.—Dr. E. R. Cullinan on duty.
Mr. J. P. Hosford on duty.
Mr. C. Langton Hower on duty.

ANNOUNCEMENTS

Engagements

ANDREWS—SMITH.—The engagement is announced between Allon R. Andrews and Helen E. A. Smith.

HALL-SMITH—STODDART.—The engagement is announced between Dr. Michael Hall-Smith and Dr. Hilda Stoddart.

LANE—NEWMAN.—The engagement is announced between Donald J. Lane and Audrey M. Newman.

TABOR—WHITE.—The engagement is announced between Dr. Arthur S. Tabor and Dr. Shiona J. White.

Births

CARRICK.—On July 4th, to Muriel, wife of Dr. David Carrick, a daughter (Eugenie Sarah Anne).

DUFFY.—On May 23rd, to Juliet, wife of Dr. Thomas Duffy, a daughter (Nicola Mary), sister to Christopher.

SINGER.—On July 7th, to Mary, wife of Dr. Geoffrey Singer, a son (David Everett), a brother for Alison.

TIMMINS.—On June 28th, to Lorna, wife of Dr. W. L. Timmins, a daughter (Sarah Margaret), a sister for Louise.

Marriage

STEVENS—OWEN.—On June 23rd, Dr. John Henry Stevens to Noreen Catherine Owen.

Deaths

ATTERIDGE.—On June 8th, Wing-Commander Terence John Doyle Atteridge. Qualified 1921.

CRAWFORD.—On May 27th, Dr. Robert Crawford. Qualified 1907.

NOTICES

Changes of Address

DR. NOEL CHILTON, c/o World Health

Organisation, Palais des Nations, Geneva, Switzerland.

Dr. W. McLaren Thomson, 268 Sandy Bay Road, Hobart, Tasmania, Australia.

Appointment

Professor K. J. Franklin has had the title of " Professor Emeritus of Physiology in the University of London " conferred upon him, in recognition and appreciation of his distinguished services to the University and to his subject.

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EXAMINATION SUCCESSES

UNIVERSITY OF OXFORD
SECOND B.M. EXAMINATION, TRINITY TERM, 1958

Pass

Woolrych, M. E.

Supplementary Pass List

General Pathology and Bacteriology

Fuge, C. A.

UNIVERSITY OF CAMBRIDGE
FINAL M.B. EXAMINATION, EASTER TERM, 1958

Pass

Ball, P. J.
Birkett, D. A.
Carr, C. J.
Davies, N.
Gibson, T. W.
Godrich, J. E.
Harcourt, R. B.
Hedley-Whyte, J.
Humphreys, Y. P.
Mitchell, R. J.
Parker, J. D. J.
Rice, J. C.
Richards, B.
Savage, D. C. L.
Stark, J. E.
Whitworth, A.

Supplementary Pass List

Part I. Pathology and Pharmacology

Campbell, A. J. P. MacAdam, D. B. Rhys-Phillips, D.
Ridsdill-Smith, R. M. Simons, R. M. Strong, J. R.

Part II. Medicine

Campbell, A. J. P. MacAdam, D. M. Matthews, T. S.
Rhys-Phillips, D. Ridsdill-Smith, R. M. Roles, N. C.
Strong, J. R. Tooth, J. S. H.

Part II. Surgery

Rhys-Phillips, D. Ridsdill-Smith, R. M. Simons, R. M.
Strong, J. R.

Part II. Midwifery

Campbell, A. J. P. MacAdam, D. B. Matthews, T. S.
Roles, N. C. Simons, R. M.

CONJOINT BOARD :—Final Examination, July, 1958

Pathology

Lewis, J. H.

Medicine

Savage, D. C. L. Simons, R. M. MacAdam, D. B.
Seeman, H. M. I. Simpson, R. I. D. Bannerman Lloyd F.
Cawley, M. I. D.

Surgery

Simpson, R. I. D.

Midwifery

Savage, D. C. L. Simons, R. M. MacAdam, D. B.
Seeman, H. M. I. Hedley-Whyte, J. Ridsdill Smith, R. M.
Matthews, T. S. Pilkington, R.

The following have completed the examination for the Diplomas M.R.C.S., L.R.C.P. :—
Savage, D. C. L. MacAdam, D. B. Simpson, R. I. D.

UNIVERSITY OF LONDON

M.D. Examination, July, 1958

Bouton, M. J.

M.S. Examination, July, 1958

Griffiths, J. D.

Examination for the Academic Postgraduate Diploma in Public Health, June, 1958

Barwood, A. J. White, M. W. L.

ROYAL COLLEGE OF SURGEONS

Final F.R.C.S., May, 1958

Fuller, A. P.
Currie, J. C. M.
McKluskey, K. A.
Girling, J. A.
Rohan, R. F.
Ross, J. Graham

Primary F.R.C.S., June, 1958
Faculty of Anaesthetists

Bush, G. H.
Voysey, M. M.
Elliott, C. J. G.
Whittard, B. R.
Lodge, A. B.

THE HEALTH SERVICES OF VICTORIA AUSTRALIA

by **A. DOBBIN**

In order to understand the arrangements for health services in Victoria, it is necessary to remember that Australia is composed of six State Governments and a Federal Government. Victoria is in the south-east area of Australia, with a population of 2½ million.

The responsibility for health services in Victoria is divided between public bodies on the one hand, and private enterprise on the other. We shall deal with the activities of the public bodies first. These are :—

1. The Commonwealth Health Department, centred in Canberra.
2. The State Health Department.
3. The City or Shire Health Departments.

There is, of course, some overlapping of responsibilities.

The Commonwealth Health Department is financed from the Federal Budget. Its duties are limited to the following :—

1. Maintenance of supervision of immigrants to exclude the entry into Australia of tropical diseases, especially smallpox and psittacosis. Medical officers visit each ship and plane when it arrives and inspects the immigrants. Those who have contacted known cases of smallpox or other tropical diseases are quarantined in isolation stations situated near each port.
2. This Department is also responsible for supervising the immunisation of intending overseas travellers.
3. For the last four to five years the Commonwealth Health Department Pharmacy Section has been arranging the free distribution of life-saving drugs to those people whose doctors prescribe them.

No hospitals are run by the Commonwealth Government, but through the States it allocates money for the partial support of hospitals. This money is paid to the hospital by the local State Government, on the basis of a certain sum per day per occupied bed. As these sums of money are not equal to the cost, the patients are charged a fee as well, varying with their ability to pay. Even

thus, the cost of running the hospital is not met, and most hospitals in Victoria are making every effort to economise.

The Federal Government Health Scheme is a form of voluntary insurance against medical and hospital expenses. A citizen arranges for an insurance policy with an insurance company, and pays a regular weekly sum. When he, or a member of his family, have an illness, he pays the doctor and hospital out of his own pocket, obtains receipts, which are then submitted to the insurance company. After a period varying from two to nine months, the insurance company reimburses him with a proportion of the sum paid. Half of this reimbursement comes from the Federal Government.

For example :—John Smith is examined by a doctor at his surgery. Smith pays the doctor a fee of 17s. 6d., gets a receipt which he promptly sends to his insurance company. After a while he receives a cheque for 12s. reimbursement. Of this latter sum, the insurance company pays 6s., the other 6s. being paid by the Federal Government through the insurance company.

The State Government Health Department is responsible for providing hospital services for epidemic infections, tuberculosis and the mentally ill.

The only free ambulance service is that provided to convey children to the Infectious Diseases hospital.

A special hospitals commission handles the allocation of State funds for hospital subsidies, and has considerable influence in decisions of local communities concerning their hospital needs and management. The Hospitals Commission, however, does not manage any hospital directly. The management of Victoria's hospitals is in the hands of management committees, which are composed of representatives elected by Life Governors of the hospital. (A life governor is one who has contributed over a certain fixed minimum sum at one time, this minimum sum varying from one hospital to another, but it is usually a large sum.)

These Hospital Management Committees usually complain of financial difficulties. Recently these complaints have been louder and more emphatic. The business manager of the Royal Alfred Hospital, Melbourne, said at a public meeting recently, that his hospital (800 beds) was so short of money that it could continue its operations only by borrowing money from private trading banks, that he was constantly increasing the amount borrowed from them, and that there was a limit to the time that this policy could continue.

Other hospital managers have made similar statements in their annual reports.

The population of Victoria has increased rapidly in post-war years and, despite the building of some suburban and country hospitals, there is a grave shortage of hospital beds. Recently, the chairman of directors of the Royal Melbourne Hospital stated, regarding this shortage of beds, that " the hospital position is so bad that it cannot possibly be exaggerated."

Owing to shortage of money, the salaries of nurses are inadequate compared with salaries in industry, and this is considered widely to be one of the main reasons for the shortage of trained nurses. This shortage is so acute that several hospitals have wards unused because of their inability to staff them.

The disparity in comparative salaries is such that the Matron of Victoria's largest hospital is paid less than many cooks. As a result, there is also a grave shortage of applicants for vacancies as matrons or charge sisters and, occasionally, management committees have no choice but to appoint unsuitable persons to responsible positions.

The State Government maintains a number of services such as a Free Mass Chest X-ray Service. This is part of its campaign against T.B. The Government T.B. Bureau also employs doctors who act as consultants, and maintains an Out-Patient Department to which suspected cases of T.B. are sent by local doctors.

This T.B. Bureau also sends nurses and doctors to schools to do Mantoux skin tests on the pupils, X-rays positive reactors and to immunise negative reactors against T.B. by injecting B.C.G. Vaccine.

The State Epidemic Infectious Hospitals are adequate and well run, and enjoy a good

reputation. As mentioned before, there is an efficient ambulance service associated with these hospitals.

There are also a number of tuberculosis sanatoria run by the State Health Department. These are also well run, some of them have ex-patients' associations, who assist in running the sanatorium in which they have been patients. The ex-patients assist by attending to some needs of the patients, organise entertainments for them and supply tasty extras for their diet. They also supply reading material and visit the inmates from time to time.

The State Government has paid more attention recently to the problem of the treatment of Cancer. A new cancer clinic and hospital is now operating. There is also a good home nursing service, whose members visit cancer patients in their homes after their discharge from hospital where they have been treated, either surgically or radiologically, or both.

The State Health Department is also responsible for providing hospitals for the treatment and care of the mentally ill.

The standards in these hospitals, of which there are many, had not kept pace with the advances in Psychiatry until some senior staff changes were made recently. Now strenuous efforts are being made to improve the mental hospitals, both in accommodation, amenities, nursing services and therapeutic facilities. Much more remains to be done, however.

Among the State Health Department's interests is that of industrial medicine. In this section, a small group of doctors do good work in investigating working conditions, especially in noxious or dangerous trades. As a result of this work, the State Government, from time to time, issues enactments of laws which are added to the Health Act, concerning the proper safeguards necessary for the protection of workers.

The State Education Department employs a number of doctors, dentists and nurses who do regular examinations of schoolchildren, but there is a marked shortage of skilled personnel available.

The City Council of Melbourne maintains a Health Department employing a number of doctors and nurses whose duty is preventive work, such as immunising children of preschool age against pertussis and diphtheria. This department also supervises the Infant Welfare section, which is staffed by specially trained nurses. The City Health Department also supervises a small number of creches and kindergartens in the city area.

Country town councils and rural area councils each have a Health Department which is staffed by a minimum of a Health Inspector (usually with some sanitary training) and a part-time Medical Officer, whose duties are limited in most cases to minor tasks, and the issuing of an annual report on the health of the local community.

This office of part-time Medical Officer of Health is very widespread, and what duties he performs are dependent on what knowledge he has of preventive medicine, and what time and energy he has after the exigencies of his private practice are fulfilled. Most councils instruct their Medical Officer to arrange the immunisation of local children at least against pertussis. He also, with the help of the Health Inspector, is responsible for the administration of the State Health Act in his own locality. He may also supervise the work of the local Infant Welfare Centre.

The General Health Services

Most of the medical attention in Victoria is provided by doctors, self-employed, working in their own homes in a locality. Some have offices in a central district and live in an outlying area. Most of these private doctors work long hours, or are available on call 24 hours a day for months at a time. This is an old tradition in Victoria.

When a private medical practitioner needs a holiday, he must employ a locum tenens who will do his work for the period of the holiday, which is usually two to three weeks. When a medical student qualifies, he generally takes employment as a resident medical officer in a General Hospital for one or two years. During this time he will work for six months in a medical ward. For the next six months he will work in a surgical ward. If he continues working in hospital, he may

either go on to an obstretic hospital or a children's hospital as a resident medical officer. He may, on the other hand, decide to specialise in some branch of medicine, and apply for a position as a senior resident medical officer or registrar, after which he will study intensively in order to sit for examination for a senior degree.

Most doctors, however, after working for one or two years in a hospital, will obtain a position as an assistant to an older general practitioner, and after a short period (one or two years), will become a partner to the older man, or will purchase the goodwill of an established medical practice in another district.

Specialists

Those doctors who decide to become specialists, after having obtained senior qualifications, must apply for a position as a junior consultant in a large teaching hospital.

Having obtained such a position, they work for at least one whole day per week in the hospital without remuneration. For an income they depend on the patients who are sent to them by general practitioners for a specialist opinion. Such patients are seen and examined by the young specialist in his office, which is usually centrally situated in the City of Melbourne. The majority of specialists will spend at least one year studying overseas, usually in London Hospitals. Thus we see that the senior staff of the general hospitals is composed of specialists who work one day a week each in the hospital without remuneration.

The Superintendent of the hospital, the senior anaesthetist, the senior pathologist, the bacteriologist and the biochemist on the other hand, are usually full time employees of the hospital, and are paid by the hospital.

There is no provision by the Government in Victoria for sick pay or retiring pensions for doctors. This is left to the medical people themselves, who must try to earn enough money to provide for their old age or for periods of inactivity due to ill-health.

Research

There is not much research activity in Victoria. The main hospitals publish few papers. A number of specialists will publish short papers on clinical material in the A.M.J., which they have gathered during their work.

There are some research activities in the Melbourne University, and also in the " Walter and Eliza Hall " Institute and the Baker Institute.

The Colleges of Physicians and Surgeons publish archives, as do also some other branches of medicine. In the whole of Australia, there are approximately eight medical journals, published by various bodies. Here are their names and source of publication :—

1. The Bulletin of the Post Graduate Committee in Medicine.
   Published by the University of Sydney, N.S.W.
2. The Australian and New Zealand Journal of Surgery.
   Published by the Royal Australian College of Surgery.
3. The Australasian Annals of Medicine.
   Published by the Royal Australian College of Physicians.
4. The Australian Medical Journal.
   Published by the Australian Medical Association.
5. The Australasian Journal of Experimental Biology and Medical Science.
   Published by the Librarian, University of Adelaide, S.A.
6. The Australian and New Zealand General Practitioner.
   Published by Butterworth & Co., 6-8 O'Connell Street, Sydney, N.S.W.
7. The Australian Journal of Dermatology.
8. The Transactions of the Ophthalmological Society of Australia.

Domestic Nursing Service

There is, in the inner suburbs of Melbourne, a nursing service known as the Melbourne District Nursing Service. On the request of a doctor, this group will send a nurse to look after a patient in his own home. The fee for this service varies with the ability of the patient to pay.

In the outer suburbs, there are a number of nurses, self-employed, who visit homes on the request of the patient or doctor. Some

nurses are qualified in obstetrics and attend women during their home confinements which are sometimes not attended by a doctor.

Country Hospitals

In the large country towns, the hospitals are organised on the same basis as the main city hospitals. For the smaller country towns and rural areas, however, there is a different arrangement, known as the Bush Nursing and Hospital Service, which has been in existence for many years. (Note :— " Bush " is the Australian word for country areas. When someone says he is going " bush," he means he is going to the country.)

When the people of the newly settled areas want a hospital, they hold a public meeting to discuss the project, and ways and means to achieve it. The community then start to raise money by holding functions such as concerts, dances, parties, etc.

A house is then bought, or, if none is available or suitable, a building is erected to house the hospital, usually designed to accommodate anything from four to twelve patients.

Much of the work in building and painting the hospital is done in the spare time of the men of the community. During the preparatory period, the local committee, which was set up by the general meeting, writes to the Secretary of the Bush Nursing Hospital Service in Melbourne, informing him of the project and requesting guidance and technical assistance. This is always granted, but no financial assistance is given as a rule. The central body arranges for the purchase of equipment, beds, sterilisers, theatre table and light, linen, uniforms, etc., and the supply of nursing staff.

When the Bush Hospital is functioning, the local people help to maintain it by gifts of fruit, eggs, firewood and labour, etc. The labour is given in a special way ; e.g. working bees are arranged when some job needs doing, a number of people gather at the hospital and together they tackle jobs such as clearing and tidying the garden, chopping firewood, painting the wooden building or erecting an extension, etc.

Financially, the hospital is maintained through a Hospital Scheme. A local committee collects a sum of money, say sixpence a week from each family. In return for this weekly contribution, any member of the family may receive hospitalisation for a reduced fee. This Bush Hospital Scheme has been very successful, and there are few country towns without a hospital.

When the towns become larger, the nature of the hospital changes, and it is run more on the lines of the city hospitals.

Pharmacy Services

When a patient receives a prescription from his doctor, he takes it to the Pharmacist, who is usually a qualified person, self-employed, who has rented a shop in the main shopping area of the town or suburb. The pharmacist makes up the prescription and sells the medicine to the patient. There is usually more than one pharmacist in the same street, but they observe the usual shopping hours of 9 a.m. to 5.30 p.m. Some are resident in the premises behind the shop, and are able to give service after hours.

Friendly Societies

In Victoria there exist a number of organisations known as Friendly Societies. These are organisations, mainly of workers, which negotiate agreements between themselves and the local doctors about rates of payment, usually on the basis of an annual capitation fee. The societies also run pharmacies which dispense medical prescriptions for its members. Most members of the working and lower middle class in Victoria belong to one or another of such societies, of which there are about twenty-six in number.

Since the advent of the Government Health Scheme, mentioned above, the character of these societies has changed and, while they still run their pharmacies, the method of paying the doctor has changed, and the societies are now acting more as insurance companies, assisted by the Federal Government, in paying back portion of the fee paid by their members to the local doctors.

Pensioner Medical Services

People receiving pensions, because of inability to work due to chronic ill-health, men over the age of 65 and women over the

age of 60 years who are in receipt of the Old Age Pensions, are entitled to free medical attention and free medicaments. Doctors are paid for this attention on a fee for service basis, the fee being approximately two-thirds of the standard private fee. This scheme is financed by the Federal Government.

Repatriation Medical Services

Former members of the Australian armed services suffering from illnesses or disabilities accepted as being due to war service, are entitled to treatment for those conditions at the expense of the Repatriation Department of the Commonwealth Defence Ministry. Local medical officers are appointed from among the general practitioners in the area, and are paid for their services on a fee for service basis, at the rate of 75 per cent of the standard fees. The Repatriation Department also maintains its own specialist and diagnostic services, an Out-Patient Clinic and a hospital in each capital city. These hospitals are very well equipped and have ample beds.

Summary

While there are still many difficulties to be overcome, the health services of Victoria have functioned well to date. Its personnel, in the main, work conscientiously and well for long hours. As a result, the health of the people is good, the infant mortality rate is one of the lowest in the world, and the gross death rate is also one of the lowest in the world, being 9.44 per thousand people in 1953. For comparison, the death rate in that year in the U.S.A. was 9.3 per thousand, Great Britain 11.6 per thousand, Egypt 33 per thousand and the U.S.S.R. 8.9 per thousand.

LOCUMING IN AUSTRALIA

by **R. J. KNIGHT**

In January I was able to take some leave in Australia. I went to Melbourne, and found that I had much more time on my hands than I had expected. As the registration of doctors is conducted by the Medical Board of the State of Victoria, which meets on the second Tuesday of each month, I had to wait three weeks before I could be registered. When I had paid the fee of three guineas, and deposited a passport photograph of myself with the Secretary to the Board, I went to see the three medical agents and left my name with them. I learnt a lot about the prospects in Victoria from them, one of them was the best advertiser for Victoria that I have met. My visit lasted an hour and a quarter, and I hardly said a thing. In spite of the demand for locums, no jobs materialised, and I was resigned to settling in the anaesthetic department of the Royal Melbourne Hospital, which was a very interesting and instructive place, but which would not repair my finances, which were weakened as a result of flying from Singapore. One morning I was called to the telephone and asked if I would be willing to start a job that afternoon, as a doctor had just died and his wife wanted to keep the practice going.

The practice was in a large country town. The house and surgery were in the same building, and had been built within the last

nine years. Brick built, the house had two storeys, with the surgery in the usual bungalow style of the Australian house. I have not seen a better designed surgery, though I have read about them. This had been built for two doctors. It had one consulting room, with an examination room kept for X-ray, ultra-violet and infra-red ray work, leading off one side, and a treatment room, leading off on the other. The other consulting room had a treatment room attached. There was a large waiting room and an office, an X-ray darkroom, and a patients' lavatory. Carpets, with a good pile, were on the floors, except in the treatment rooms, which had linoleum. The building was light and airy, the rooms being high. It was a pleasure to work there and, except for the basins being a few inches too low for my lumbar comfort, I had few faults to find with the equipment. It was a very well equipped practice, and there was even the apparatus for tubal insufflation with CO_2.

As an introduction to general practice it would be hard to find a better. The news had got round that the doctor was dead, but it was also going round that there was a young English doctor looking after the practice. I was broken in gently, eight to fourteen patients a day, so I had plenty of time to examine and treat them, and have a bit of social chat. The patients were paying for a consultation in the surgery, so they were entitled to the more leisurely methods of private practice. As there is no other sort of practice in Australia, it is not often that the doctor can spend time on the frills. It was very interesting to me, brought up in the " No Payment " era, to see notes being pulled out of the hip pocket as we shook hands and I saw him to the door. Most of the patients were New Australians, European migrants, Italian or German for the most part. It would be a great advantage to the emigrating doctor to be able to speak Italian and German, as most of those who were displaced persons after the war, learnt to speak one or other of these languages. The New Australians are good patients at paying, very few wait for the bill to be sent, they seem to like to pay as they leave. In the days that I was there I saw two women who I am sure had thyrotoxicosis. To get the B.M.R. done at the local hospital was easy, but, as I was not going to be there long, I referred them to the local consulting physician, another G.P., who arranged for them to be admitted when it suited them. The X-ray plant was really a large portable, but it would take chests and was adaptable for screening. I doubted my ability to read accurately chest films, as I had only seen a dozen in the last two years, so the young man worried about his chest was referred to the local X-ray firm, two G.P.'s, for his X-ray. I did use the machine for the broken bones that came my way, a child with a partly slipped lower humeral epiphysis, which had been strapped a week before, and which I immobilised in plaster of paris, an eleven-year-old at school needs a solid protection, and an old lady with a Colles' fracture. I had to give an anaesthetic for tonsils, but that was beyond my surgical experience, so the practice had to be content with the fee for the anaesthetic and not for the operation. I only had to turn one patient away, an old man who wanted his hydrocoele tapped, and I had no wide bore needles. Naturally enough there were some pregnant women to be seen and advised. Luckily, none of them decided to go into labour while I was there. In a strange hospital in a strange town in a strange country would not have been the best way to catch up after a four year gap.

One side of the practice was a trial to me, the records. The doctor's memory must have been phenomenal. He kept a large desk diary with the names and addresses and notes of the patients he saw each day. As his handwriting was not easy to read, I was always in trouble, especially when the patient could not remember when they had last come, and I had to thumb back through several days. Though there were long periods without patients, I was never bored, as his professional library was excellent. In it I found Dr. S. Taylor's *Report on Good General Practice*. This excellent book, written for the English G.P., needs to be bent a bit for Australian conditions, where the practitioner does everything he feels he is able to cope with. As the locum, I officially filled the doctor's place in the local hospital, though I backed out from any surgery, and attended his private patients in the private wing. All the G.P.'s in the town were on the staff. When I felt that I was beginning to turn the tide and holding the practice together, the Navy called me back to Melbourne. It was a blow to leave such a pleasant practice, but the thought of

getting home soon, after two years out of England, was a great consolation.

But my journey did not go as smoothly as it might have done. The Royal Air Force Hastings that I was to fly back to England from Adelaide in, was four days late. I was getting a bit short of cash, staying in an hotel. So I went to the Medical Board of South Australia to see about registering. It is one of the snags of Australian travel, that you have to register in each State, there is no reciprocity. The secretary was charming, and suggested that I would be wise to find a job before I paid my guinea for a year's registration, and perhaps waste it. Once more, illness came to my rescue. I walked into an agent's office within half an hour of him being asked to provide a locum immediately for a doctor who had just had his second coronary at the age of 45. My previous job had been caused by the same disease, a third at the age of 55. So the diseases of doctors are the same on the two different sides of the world. I was registered that afternoon, having shown my original degrees to the President of the Medical Board.

This practice was suburban. The surgery was newly-built in a growing suburb. Laid out for one doctor, it had a consulting room, with an examination room leading off, which had a door into the waiting room and one into the large office, which held the X-ray machine and a couch. There was an X-ray darkroom, and also male and female lavatories, the former with a shower. The building was run by a secretary and a nurse. Here the tempo was different. The news had not got round, and so the patients turned up in their droves. One afternoon I saw fifty-five people in five hours. I found that there was quite definitely a falling off in my efficiency and politeness after the first three hours. What can be done about that, except to stagger the surgeries, I do not know, but it is a very big problem. The surgery that afternoon was from 2 to 5 p.m. officially, but the patients had been booked by appointment from 1.30, and I was doing very well to be finished by 6.30. I would never have managed without the efforts of the nurse and the secretary, both pretty girls in their early twenties, who stayed on late everyday. This practice had a fair proportion of old age pensioners. One of these had a "little stroke," which left him troubled in his speech for a day or so. Attending him, I learnt my way round the pensioner medical service. This is paid for by the Federal Government, and costs the pensioner nothing. To get his money, the doctor gets the pensioner or his relatives to sign a form when they visit the doctor, and a different form is used when the doctor visits them. Their prescriptions are written on a special form in duplicate. Practically everything is free to the pensioner, but the free list is restricted to medicaments which have a monograph in the B.P., the general free list and a special pensioners' free list. More than once I had to rewrite a prescription so that the pensioner would not have to pay. The repatriation patients, returned servicemen and some dependants, are another Federal supported group, who have special prescription forms, in triplicate. The main bulk of the population have to pay for their medicines, except for life-saving drugs, which are laid down in a Commonwealth publication, and range from Butazolidin to Penicillin. But, so far, Penicillin V has not got on the list.

In spite of seeing far too many people, many of whom should not have been wasting a doctor's time, I enjoyed this practice, too. My only night calls in a fortnight of locuming were on my last night in Australia. I went to bed at 11, up at 12.15 to stitch a hand cut at a party, and could I remember the name of the woman accompanying the patient, who had brought her child in for me to see that afternoon. No. Then up at 5 to see a woman with biliary colic. Then up at 6 to catch my aeroplane. Both the girls and I were sad to end our work together. I would have been quite delighted to stay for three months or more while the doctor was off work, in spite of the dry and baked appearance of the city. Australia in the summer is brown, not green. The grass only grows where it is watered. The back streets of that suburb, like many other streets in Australia, were only tarmac in the middle with grit and gravel at the edges. I have never been dirtier or dustier when doing a clean job. There were fewer troubles here with the records. Cards were used, but visits were not entered on the cards. Though it is at times difficult to keep enough time to write the notes when many people are waiting to be seen, it is well worth the trouble. The human memory is not as good as some people like us to believe, and the locum has

no clues, anyway. I loathed having to start by asking for a long history when the patient came in, expecting an injection of Vitamin B complex. But just sticking a needle in is a duty which a nurse can do just as well as a doctor. However, all the injections had to be given by me, except for two patients who preferred to have the nurse stick the needle in them.

My advice to those thinking of going to Australia is to brush up their midder, E.N.T., appendix and suchlike surgery, find a nice large sum of capital, building is terribly expensive, and houses for rent are almost unobtainable, choose their State and write to a medical agent or to the local secretary of the B.M.A. I can only speak from experience of Victoria and South Australia. I have seen Perth and Sydney, both lovely cities, though I prefer Melbourne. But I have never seen any city which looks as lovely as Perth at first sight from the heights down river through trees framing the view of the Swan River, the riverside playing fields, and the buildings beyond. All the States accept English qualifications, and the only thing one has to do is register. There are plenty of locum jobs available, but they usually mean more moving than in England. The competition in the capital cities is strong, but that is where the money is made, in the industrial practices. The Australian is a city bird, the legend of the bronzed horseman always herding sheep or cattle is a hangover from the last century, as about three-quarters of the population live in the capital cities. There are few people who have a higher social standing than doctors, and there are few people who have such an assured future. How long this will last, I do not know. The Labour Party, which is not in power in the Commonwealth, though it is in power in most of the States, is pledged to bring in a Health Service. What form it will take is not known, but I hope that it will be based on a payment for service, and not on a capitation fee. The recent agitation in England for more money for the G.P. shows the weakness of the capitation fee system, though the other can be abused too.

AN INTERESTING SURGICAL CASE

by **M. J. L. P.**

It is lamentable that still in this present age useful lives are still lost owing to the limited means of treatment in the surgeon's hand to attack the increasing scourge of cancer. Inevitably there occurs such an occasion soon in any student's clinical career which imprints itself for ever in the impressionable mind so unused to the tragedy of death. The following history was one of this kind which, in spite of every effort on the part of the surgeon, the nurses, and of the patient, the disease ran its slow and remorseless course, until death came as a merciful escape.

Case History

Mrs. A. T., aged 58. Occupation, Housewife.

The patient was referred to Out-patients by her doctor, with the following letter :—

" She has an abdominal tumour in the lower abdomen. She is anaemic and has

been having injections of B 12. From what she says, she may have passed some blood per rectum and per bladder. No pain now, but has persistent diarrhoea."

She complained of feeling lifeless and short of breath. The onset of these symptoms being some two months before, since when her doctor had treated her with intra-muscular vitamin B and oral iron.

With this treatment the patient improved symptomatically, though she developed a change of bowel habit with 6-7 dark, ill-formed stools being passed each day. Two days prior to her attendance in the out-patient department, she had noticed that her urine was dark, an increased frequency of micturition. There had been a noticeable falling off in her appetite and a weight loss of about 14 lb. in three months. She had occasional griping pains in her lower abdomen which appeared to be unrelated to any intestinal upset or exacerbation of urinary symptoms. Her menopause had been some seven years earlier, with no subsequent blood loss or discharge. There was nothing relevant in the past history or the family history.

On Examination

There was some exophthalmos and definite clinical anaemia.

Eyes : nothing abnormal, except for a positive Von Graefe's sign and pale conjunctival membranes.

Neck : there was a smooth, diffuse, soft and symmetrical enlargement of the thyroid gland. There were, nevertheless, no signs suggestive of pressure on the trachea.

Chest : nothing abnormal was detected.

Abdomen : there was no tenderness, guarding or rigidity. A large, irregular and hard mass was palpable above the pubis arising from the pelvis and equal in size to a 16-week pregnancy. Rectal examination revealed no abnormality.

Limbs : there was a fine tremor of the hands.

Urine : was cloudy, though no abnormal constituents were found.

Pulse : was strong and regular at 80 per minute.

It was felt that both the history and examination justified a multiple diagnosis of :

1. Anaemia of unknown origin.
2. Primary Grave's Disease.
3. Fibromyomata of the uterus.

The patient was referred to the physicians for their opinion on her further management. They noted her weight to be 7 st. 5½ lb., and suggested that she should be admitted for investigation of her "anaemia, toxic goitre and abdominal neoplasm." This was the first occasion that the nature of the abdominal mass was thought to be malignant, although the general practitioner may have suspected this, in view of his guarded letter.

The patient was admitted to a medical ward. The history taken in the ward showed no further attacks of haematuria, but there was an increased diurnal frequency of micturition with occasional dysuria and also a story of palpitations with rare giddy spells since the onset of the condition.

Examination : she was a thin and pale lady, but with a great sense of humour.

Eyes : no exophthalmos. Von Graefe's sign negative. Dalrymple's sign present.

Neck : as before, though a soft bruit was now heard over the left lobe of the thyroid.

The physical signs in the abdomen were unchanged and, apart from a mild bilateral pes cavus, nothing more was noted.

The following investigations were performed :—

Hb.	38%
R.B.C. count	2,750,000 per c.mm.
P.C.V.	20%
MCHb.	20.1 micromicrograms
MCHC	28%
MCV	72.7 c.microns

Group O positive
B.M.R. was plus 34%
E.C.G. showed a sinus tachycardia within normal limits
Chest X-ray was normal
Stools were strongly positive for occult blood
Protein bound iodine 8.0 micrograms per 100 mls.

W.B.C. count	9,000 per c.mm.	
Neutrophils	5,760	64%
Eosinophils	270	2%
Basophils	90	1%
Lymphocytes	2,790	31%
Monocytes	90	1%

In view of the severe microcytic hypochromic anaemia, the patient was transfused with four pints of blood during the next week and the haemoglobin level was raised to 78%.

A sigmoidoscopic examination showed that the anal mucosa had collapsed and the rectal mucosa was normal up to 18 cms. At 18 cms. there was a friable mass which bled easily, and which was thought to be a carcinoma of the colon. Surgical advice was sought and the sigmoidoscopy repeated. A biopsy was taken which on section proved to have been of the normal bowel wall. A laparotomy was recommended. Two pints of blood were transfused into the patient in an attempt to improve her condition before operation and the patient's thyrotoxicosis was adequately controlled by 5 mgs. Carbimazole b.d.

A course of succinylsulphathiazole was initiated (4 grams, 6 hourly) as a pre-operative measure and an exploratory laparatomy and cystoscopy were performed. On opening the peritoneum there was a small quantity of pus free in the cavity with a large mass arising from the pelvis. This mass appeared to involve the colon, the uterus, the bladder and some small gut, all these structures being bound together by dense adhesions which may have been growth. The whole area was red and inflamed, and it was decided to relieve the partial obstruction with a transverse colostomy, in the hopes that this would lessen the pelvic inflammation. A transverse colostomy was therefore constructed and a drain left into the abdominal cavity through a stab incision. The cystoscopy revealed a possible recto-vesical fistula. The diagnosis was still in doubt following the operation, for the appearances of the mass were consistent with diverticulitis or a neoplastic mass, and the biopsy taken at the operation showed only non-specific changes of an inflammatory type with no evidence of neoplasia. The swab of the pus from the abdominal cavity produced only a scanty growth of coliform bacilli.

The post-operative progress of the patient was uneventful until six days later when the drain was removed and the stitch line examined. There was a tender indurated area below the stitch line that was thought to be a localising abscess, with profuse faecal-like discharge from the lower part of the wound. A swab was taken from the discharge, when cultured showed a proteus infection which cleared up without any chemotherapy after ten days.

After a further two weeks, a sigmoidoscopy, cystoscopy and defunctioning of the colostomy were performed. The sigmoidoscopy findings were as before, but this time the biopsy was successful, the pathologists reporting a poorly differentiated columnar cell adenocarcinoma which was probably a primary growth of the bowel. The cystoscopy confirmed the previous findings of a large fistula in the vault of the bladder, which both looked and felt neoplastic. The ureteric orifices were normal. Vaginal examination showed a mass mainly on the right side, there was one lymph node palpable in the posterior fornix, the uteris being anteverted and the cervix appearing normal. The colostomy was defunctioned, which was entirely successful, although faeces were passed quite normally per rectum for a time following this operation.

Two weeks later a pelvic exenteration and transplantation of one ureter was performed. A large mass of growth was found ulcerating into the bladder and involving the colon, uterus and small gut, so that the exact origin of the growth was in doubt. The mass was friable and extended to the pelvic walls. The lower end of the left ureter was embedded in the growth and the left kidney was hydronephrotic, both the right ureter and right kidney appeared normal. There was no evidence of metastases in the liver or in the peritoneum itself. The tumour was stripped from the pelvic walls and a few fleshy glands were found. The pelvis was dissected and the mass mobilised. The left ureter was ligated and divided high up. There was a complete pelvic clearance of bladder, uterus with ovaries and the upper portion of the vagina, the sigmoid colon and some small gut. The continuity of the gut was restored by a series of end-to-end anastomoses between the ends of the small gut and between the colon and rectum. The right ureter was transplanted into the colon about one inch above the recto-colic anastomosis. The old colostomy was left untouched and no attempt was made to cover the pelvis with peritoneum, since too much had been removed during the operation to make this possible.

During the operation, which lasted five

hours, the patient was transfused with five pints of blood and one of saline. On her return to the ward the patient was in a fair condition and had a blood pressure of 120/60. Later that day she appeared to be holding her own and the wet colostomy functioning well.

Pathologists's report on the specimen from the theatre : " there was a poorly differentiated adenocarcinoma (Grade III. Broder) of the rectal wall which had infiltrated into the adjacent structures. The uterus showed menopausal atrophy of the endometrium and myometrium."

Following the operation the blood urea rose to 88 mgs. per 100 mls., but the condition of the patient remained satisfactory until one week later, when she produced some blood-stained sputum which was found to contain a coagulase postive staphlococcus. This responded to treatment with chloramphenicol. The drains were shortened ten days after the operation, and the drip taken down : although the abdomen had burst partly open, the patient was eating and drinking well with a good action of her wet colostomy.

Three weeks post-operatively, she suddenly developed a pyrexia of 102° F., and the only abnormal physical sign was tenderness extending into the left loin and renal angle. There was no guarding or rigidity. Penicillin and streptomycin were prescribed. A swab taken from the vaginal remnant was overgrown with proteus. The pyrexia soon subsided but signs of consolidation, collapse and effusion were still evident at the left lung base. Aspiration of the chest was attempted and a small quantity of a blood-stained fluid was obtained. The discharge from the vagina improved.

The transverse colostomy was closed on February 3rd, 1957, and a sigmoidoscopic examination was performed which showed a satisfactory healing of the recto-colic anastomosis.

For two weeks following the closure of the colostomy there was a diffuse swelling on the right side which was taken to be an attack of sub-acute obstruction in view of the concomitant vomiting and failure of bowel action. This, however, improved. After this, the last incident in her stormy illness, the patient slowly recovered, and was discharged to a home for the chronic sick. Her condition on discharge was very weak and frail, though her morale was, as it always had been, enormously high ; there was no evidence of bony metastases, but she complained of a constant low back pain in spite of a negative radiological examination of her spine. She managed to control her urine satisfactorily with her rectal sphincter. Her thyrotoxicosis was still adequately controlled with carbimazole.

The patient died at the chronic sick hospital and the certified cause of death was carcinomatosis, but no post-mortem was performed.

Discussion

There was a triad of features which were obvious and yet were difficult to inter-relate, hence the differential diagnosis was both large and varied. This triad was : severe anaemia, loss of weight and the abdominal mass. Diverticulitis, neoplasm and degenerative fibromyomata were some of the possible diagnoses tentatively offered at different times during her treatment.

It was felt when the patient first attended out-patients that the loss of weight was due to her toxic goitre, that the anaemia was an enigma and the mass a fibroid.

The diagnosis of a uterine fibroid of such size in a post-menopausal woman with her symptoms is unusual, for they commonly occur earlier (35-40) and are, to some extent, hormone dependant tending to arrest at the menopause which is later than normal. The physical signs of a uterine fibroid are of a hard, smooth lobulated swelling rather than " a hard irregular swelling." Anaemia with loss of weight can be the cardinal presenting symptoms of a fibromyoma, but it never appears without severe menorrhagia.

Whilst she was in the care of the physicians a diagnosis of carcinoma of the bowel was made, but it was impossible to prove this by biopsy for some time. However, this is the classical diagnosis for a disease presenting with slowly progressive wasting, unresponsive anaemia when actively treated and an abdominal mass. This is supported by the

change in bowel habit, which persisted after the oral iron was stopped.

A possible diagnosis of diverticulitis was considered after the laparotomy when pus was found in the peritoneal cavity and the fistula (recto-vesical) was discovered, for diverticulitis may present with a history of diarrhoea with the passage of mucous and blood with a tender mass in the left iliac fossa and fistula formation. The associated peri-diverticulitis forms dense adhesions and may produce an acute or sub-acute obstruction. On laparotomy there are often enlarged glands due to inflammation, which may confuse the issue further. However, some neoplastic disease of the bowel was the safest diagnosis since it concurred with all the features of the illness, and made some form of laparotomy inevitable.

The truly remarkable thing about the whole of this case was the enormous courage which the patient showed and managed to transmit to all concerned in her care. Without this factor, it is doubtful whether such a major operation would have been attempted on what was a hopeless case, but she refused to give up hope, and so all joined in her zest for life and struggled to prolong it.

Summary

A female patient of 58 years was operated on for carcinoma of the colon. The presenting symptoms were those of anaemia and loss of weight. The presenting signs were those of anaemia with a large abdominal tumour. A colostomy was first fashioned to alleviate the urinary infection from the recto-vesical fistula, and this was followed by a pelvic exenteration and transplantation of the right ureter into the colon.

The convalescence was stormy, with bouts of wound sepsis and also respiratory infection. The colostomy was eventually closed and the patient discharged. She died some three months after discharge.

ACKNOWLEDGEMENT

I should like to thank Mr. G. W. Taylor for his advise and helpful criticism.

THE OPSONIC INDEX

by **R. FOSTER MOORE**

Having recently been under the care of one of our Surgeons, to whom I have every reason for being profoundly grateful, as indeed I am, I fear lest it may seem churlish of me to utter even the faintest whisper of complaint, for I was subjected to every sort of investigation which seemed to promise any useful information—except one ; my Opsonic Index was not investigated !

I hesitated to speak to my surgeon direct, and so, behind his back so to speak, I approached his Senior Registrar as to the reason for the omission. He was quite polite about it, but admitted, to my surprise, that he hadn't a notion what the Opsonic Index was.

Later, I had a visit from a contemporary colleague, whom I told of my experience ; he murmured something about " abysmal ignorance " and " highly reprehensible,"

which fortified me in my feeling of duty to expose such ignorance in high places.

The Opsonic Index is ancillary to the curative vaccines, so that a short enquiry into the history of these becomes necessary, but I should say that this tale has neither the permission, nor necessarily the approval, of either Professor Garrod or Dr. Brewer.

The curative vaccines were introduced at the beginning of the century, and my first knowledge of them was acquired at a meeting of the Medico-Chirurigical Society, which Society was afterwards merged into The Royal Society of Medicine.

On this particular occasion a member reported six cases of varied ailments, all of which, he stated, were due to pyorrhoea ; they had been treated by vaccines prepared from the mouth which, surprisingly, as it seemed to me, were also administered by the mouth, and he claimed that all the cases were " favourably influenced by the exhibition of the vaccines " : Oh ! that dreadful cliché, a compound, as it is, of wishful thinking and wilful self-deception.

The vaccines were on their way, and what a vogue they were to become.

The Profession, naturally, was very ready for what might prove a successful line of treatment ; patients were anxious to talk about and advertise the fact that they were under, what they took to be, a highly scientific form of treatment, and the drug houses rose to the occasion, and found it highly remunerative : all the omens were favourable.

The vaccines were supplied in alluring looking phials of various colours ; they were packed neatly, and were identified by a combination of figures and letters with a show of most meticulous accuracy, and, as treatment consisted of a course of injections, often followed by subsequent courses, ample time was provided for many patients to recover.

After the first impetus had a little subsided, it was discovered that the vaccines must be autogenous ; a definite advance ; the second stage was reached ; vaccines were in full flood.

As time went by, and lest interest in vaccines should flag, it was announced that it was essential that the dosage be accurately controlled, and to this end, the " Opsonic Index " was introduced.

The Opsonic Index, in short, was arrived at by treating the blood with a suspension of a culture of the causative organism and counting the average number of the organisms which were ingested by a stated number of the large mono-nuclear leucocytes : the third stage was arrived at, where the vaccines were autogenous and the dosage was accurately controlled ; it was felt that the treatment was now placed on a secure scientific basis, and so things continued. But again, in due course, it came to be realised that the results were not so good as could be desired, some further modification was called for, that in fact the vaccines should be sensitised ; and again an improvement in the results was claimed ; but again, when the treatment was all but moribund, it was put forward that detoxication was essential ; but it was too late, a definite recession had set in, this, the fifth modification, was in vain, the curative vaccines faded out, and with them, the Opsonic Index ; both are, I believe, defunct. I remind myself how often I had predicted that the time would come when they would have to be made on a Monday afternoon and stirred with a wooden spoon before they did good.

Of the Opsonic Index, the very name of which seems to be forgotten, I think we may adopt, what our own Betsy Prigg of St. Bartlemy's said of Mrs. Harris, to our purpose, and say, " We don't believe there's no sich an Index." Dr. Gee used to say, " Make haste to use your new remedies before they lose the power of working miracles." I wonder how many of the new remedies of these times will, in the course of a quarter of a century, have survived, and how many have been relegated to the limbo of forgotten miracle workers.

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SPORTS NEWS

VIEWPOINT

An apology is offered to readers of the *Journal* for the fact that the article on Bridge, printed in June, made rather confused reading. As they will have realised, this was due to the fact that two paragraphs intended to appear in separate journals were printed together.

Croquet, a rather more sedate pastime than the energetic ones usually associated with students, seems to be very popular at Charterhouse at present. Much hard practice is put in on most fine evenings by prospective winners of the Magnum of Champagne, offered by the Warden, for a doubles competition. The state of the lawn will, however, probably ensure some surprising results.

The Cricket Club appear to be doing well in the Inter-Hospitals competition again this year. They have so far reached the semi-final. Last year they reached the final, but were then unfortunately beaten by Guy's. It is hoped their run of success will continue.

SPORTS CALENDAR

August

Wed., 6th.—Golf *v* St. Mary's at Moor Park.

Sat. 9th.—Tennis *v* Roehampton, away

Sun. 17th.—Cricket *v* Bromley, away, start 2.30 p.m.

Wed., 20th.—Golf. Summer Meeting.

Wed., 27th.—Golf *v* St. George's, at Dulwich

★ ★ ★

LAWN TENNIS CLUB

The results of the season have been most encouraging so far ; out of seven matches played, only one has been lost. Unfortunately, this was the most important U.H. Cup match against Guy's. It is the third year running that we have met them in the first round, and they have won the competition for the past seven years ! On an afternoon of threatening weather and strong wind, our first pair (Duff and Richards) excelled themselves by winning all three of their matches. The rest of the team was unable to follow the lead. The progress of the match was assisted by a spot-diagnosis of a Meibomian cyst in the eye of Devereux, their No. 1 player ; but this was offset by Seaton's pyrexia !

Team :—**E. G. Cantrell, D. A. Richards, T. B. Duff, A. J. Gordon, A. T. Seaton, J. Pennington.**

The Cambridge tour was most enjoyable, but unfortunately spoilt by rain, which was responsible for cancelling the match against Emmanuel. This might have been a match to really test our gut, since they were the 1958 winners of the Senior League and the singles and doubles cuppers.

Rain did not stop play against Clare, whom we beat 7—2. Dr. C. S. Goodwin joined us for the match, but, unfortunately,

the Clare team was somewhat depleted by Tripos. After a very cold shower, we all piled into a rather small car to take Richards to Addenbrookes to receive attention (he said for a boil on his leg !).

Team :—**E. G. Cantrell, D. A. Richards, T. B. Duff, C. S. Goodwin, A. J. Gordon, A. T. Seaton.**

Other 1st VI matches have been quite easy and undistinguished.

The 2nd VI have also had some good matches, and there are signs of promising talent that should be ready to distinguish itself in later years with more experience.

Results

1ST VI

		F	*A*
Guys (U.H. Cup)	L	2	—7
Clare College (Cambridge)	W	7	—2
St. Mary's Hospital	W	8½	— ½
St. Thomas' Hospital	W	9	—0
St. George's Hospital	W	9	—0
2ND VI			
Middlesex Hospital	L	3	—6
London Hospital	W	6	—3
Charing Cross Hospital	W	6½	—2½

E. G. CANTRELL

★

RIFLE CLUB

N.R.A. United Hospitals' Cup Competition, July 11th.

One team of four competed for this cup, which has been held by Guy's for some years. Despite an exciting match, we failed to take it from them by a narrow margin, and were placed second.

The match was fired over 200, 500 and 600 yards in perfect weather, with a variable wind which became more difficult to judge later in the afternoon, and at the longer ranges. We were very grateful to Mr. E. J. Elgood for his aid as a wind-coach, and only regret that we were unable to produce a standard of shooting comparable to that which he himself accomplished when at Barts. At the completion of firing at 200 yards we were five points down on Guy's, and this lead was increased at 500 yards to one of seven points. Victory was placed within our grasp at 600 yards, when Guy's dropped five points with a bullseye fired at the wrong target, but our own shooting proved erratic at this range, and we only held them to their seven point lead. F. A. Strang is to be complimented on his steady performance through the ranges, particularly as he has not fired on many previous occasions.

Scores

	Yards 200	500	600	*Agg.*
F. A. Strang	30	32	32	94
G. R. Hobday	31	31	31	93
R. P. Ellis	31	32	30	93
J. D. Hobday	30	33	27	90
			TOTAL	370

Guy's A, 377
London and Guy's B, 356
St. Mary's, 354

★

ATHLETICS

The United Hospitals' Athletics Championships

These were held on Saturday, June 14th, at Motspur Park, the heats for certain events having been completed the previous Wednesday.

The most striking feature of this year's meeting, after mentioning that the weather was fine, which, needless to say, is not always the case, was the generally poor standard of performance, compared with recent years. In view of this, the marked absence of Bart's competitors was all the more unfortunate. Even allowing for a regression from our former greatness on the athletics field, we could easily, with a full team, have been placed in the first three. As it was, only four people from the hospital competed on the Saturday, and few more on the Wednesday. One gentleman put up the best performances in two events, as a non-competitor, having failed to appear for the qualifying rounds, and several others who might have done well were not present at all.

Of those from the hospital who did compete, all did well.

C. P. Roberts won the High Jump, and was third in the Steeplechase ; J. Stephens was second in both the Shot and Hammer ; C. Craggs was third in the Shot and sixth in the Hammer ; and J. Sugden was third in the Pole Vault.

It was indeed a sad day for Bart's, which saw so few representatives of the hospital present for a meeting at which our past record is bettered by only one other hospital.

One point might be worth the attention of the committee of the club. At least one person was unable to compete, because he only distinguished himself at Sports Day the week before, by which time the entries had to be in. It may be advantageous to arrange Sports Day at such a time as to allow for such a contingency in future years.

LETTERS TO THE EDITOR

Sir,

The provocative Editorial in June's *Journal*, suggesting that the "masters" might be out of step with the "men," was refreshingly frank and sensible. Controversial subjects, especially those in connection with Authority, are rarely dealt with in the *Journal* and, today, when feelings against disciplinary anomalies run high, it is apt that the Editor of the *Journal* should use his column as the mouthpiece of opinion in the Hospital.

In this matter the *Journal* echoes current opinion —a welcome change from the reports of functions and sporting events which are, invariably, printed many months later.

I am, etc.,
R. BONNER-MORGAN.

Abernethian Room,
St. Bartholomew's Hospital.

Sir,

Is it really "increasingly obvious that the masters are becoming more and more out of touch with the views of the men" or, indeed, "that students' feelings are not respected" by the masters? This is certainly an inaccurate and unjustified generalisation

If this sad state of affairs were true, surely it would be as much a self-condemnation of ourselves, as a criticism of our masters. When a student feels strongly about anything, he will not hesitate to express his feelings. What is to prevent him from discussing his opinions with his master? Undoubtedly a wise man will respect those views *if* the views are wise also.

The sparsity of letters from Students in the *Journal* recently would indicate either a deep apathy amongst students over "important decisions which concern their future," or else—more likely—that they are fairly satisfied with the present status-quo. In either circumstance, "regular and uninhibited discussion between the Dean's staff and students" would be very pleasant, but might go no further in bridging a void which does not exist.

Yours, etc.,
PIERS RECONDON.

Abernethian Room,
St. Bartholomew's Hospital.

Sir,

Students do express themselves forcibly in the Abernethian Room, in the canteen and in the square, but not through letters in these columns, nor in direct representation to the staff.

EDITOR.

BOOKS REVIEWED

AT DOCTOR MAC'S: A DOCUMENTARY ENTERTAINMENT by Peter Quince. **Published by J. M. Dent, London.** 277 pp. Price 15/-.

Readers of *Left-handed Doctor* by this author will anticipate with pleasure the enjoyment of this new publication. The pen-name of its author conceals the identity of a well-known Bart's man, and it is obvious that the writer is more than vaguely acquainted with the setting of his latest book. Peter Quince was medical superintendent of a private sanatorium for over twenty years, and his superb craftsmanship enables him to present a remarkable pen-picture of life in such an establishment. Readers feel that they are living with the inhabitants, sharing their problems and experiencing the strange atmosphere of life in a sanatorium.

Medical men, patients and the general public will enjoy this entertaining novel, which might favourably be compared with a documentary of the highest class. It instructs while it entertains, and deserves the same success as its predecessor.

PURBECK MARBLE. Illustrated by Grace Lodge. By Llewellyn Pridham. **Published by Hutchinson & Co.** 140 pp. Price 10/6d.

Several Bart's men have achieved distinction in subjects outside medicine, and Dr. Pridham's book for children of all ages adds to these contributions in the literary field. A Dorset man, the author applies his local knowledge of the quarries that produced the famous Purbeck marble for building some of Wren's London churches, to produce a fascinating story. The ingredients include two teenagers and their adventures with pirates and highwaymen in an endeavour to secure a contract to supply the marble for Sir Christopher Wren's buildings.

Attractively produced, this book is a welcome addition to the juvenile bookshelf, and the author is to be congratulated on achieving success in that most difficult task of writing for children.

Ann Thornton, aged twelve, writes: "*Purbeck Marble* is a very exciting novel for children of the ages from nine to fifteen, and even older. It is based on an historical setting, and for children who like a little about the sea, a little about horses, and a little of mystery and thrills, *Purbeck Marble* is the ideal book."

THE MEDICAL PRACTITIONERS' HANDBOOK. British Medical Association. **Published by B.M.A., London, 1958.** 285 pp. Price 12/6d. Members of B.M.A. 10/-. Final year students and graduates in first 3 months after qualifying 5/-.

The new edition of this useful reference book contains a wealth of information, much of which is difficult to trace elsewhere. Sections are devoted to Registration; National Health Service; Entry into Practice; Contracts and Agreements; Postgraduate Education; Individual Medical Defence, and other topics. Appendices provide details of appliances and chemical reagents; the duties of doctors under the Dangerous Drugs Acts; Industrial

medical officers ; and some useful addresses.

This is but a sample of the features rendering this *Handbook* a source of information that can be consulted to advantage by all medical men. Concise and authoritative, it is of particular interest to the newly qualified, but will be appreciated by all engaged in medical practice.

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